A. Yes.

Q. At what facilities have you certified individuals for involuntary hospitalization?

A. I have in the last four years done about 100 to 150 9.37 commitments to Saint Francis Hospital with recommendation for hospitalization, that requires a second physician there at the hospital to admit, but certainly with my commitments, the police, whoever are committed to take the person against their will to the hospital or to the hospital for hospital treatment. Before that I worked inpatient and occasionally I got called to the admissions unit to do a 2 PC, I believe when somebody got ill.

Q. While you were at Hudson River, approximately how many 2 PC's, physician certificate evaluations did you conduct?

A. In the ten-year period that I was at Hudson River from 1992 to 2002, I probably conducted about twenty to thirty perhaps would be my best estimate.

Q. Let's go back a second to what you are doing

now with Saint Francis. Are you considered a designee of the Director of Community Services?

A. Yes, I am.

Q. And have you been committing individuals pursuant to this position?

A. Yes, I have.

Q. What is your understanding of the criteria for commitment pursuant to -- (interrupted)

A. On the 9.37.

Q. Pursuant to Section 9.37.

MR. PEEPLES:

Do you understand the question?

THE WITNESS:

Yes. What is the criteria pursuant to the 9.37 commitments.

MR. PEEPLES:

You can answer.

MR. BROOKS:

Q. You can answer.

A. I would say the -- I would say when a person has mental illness that deems them dangerous imminently to themselves or others, those would be my criteria. Or inability to

because of the mental illness get shelter, food, proper medical care that was going to be a substantial risk to their welfare. That's the criteria.

Q. To the best of your knowledge of the law, are there any other requirements for commitment under Section 9.37?

A. Not offhand -- well, part of it, I guess, would be that they don't voluntarily want help also.

Q. Is there anything else?

A. Not that I recall. Nothing that hit me.

Q. To the best of your knowledge, what are the requirements for commitment under Section 9.27?

A. 9.27?

Q. Yes. If I may add just for clarification purposes, would you agree that Section 9.27 and 9.37 are the two Physicians' Certificate Law?

A. Yes.

Q. So just to be clear, if I talk about 9.27 or the 2 PC Law, we are talking about the same thing?

A. Yes.

Q. Just for clarification purposes.

A. Thank you.

MR. BROOKS:

Off the record

(OFF THE RECORD DISCUSSION)

A. The criteria for the 9.27 are basically similar to the 9.37 with not quite as much emphasis on imminent, if you will, that may be not quite as imminent, but still a person that is dangerous to himself or others or has an inability to function in terms of getting food, shelter, clothing, medical care due to their mental illness and otherwise doesn't want to get voluntary care. Also, that requires care and treatment in the hospital and not less restrictive alternative places.

Q. To the best of your understanding, are there any other requirements in the law?

A. Not that I recall right now.

Q. I'm going to read a number of statements and

overwhelming?

MR. PEEPLES:

Objection to the form of the question. If you understand it, you can answer.

A. When you say "involuntarily," you mean the 2 PC?

MR. BROOKS:

Q. Yes.

A. Can you repeat that?

MR. BROOKS:

I'll rephrase the question.

Q. Which of the following four degrees of risk best categorizes what the law requires, as is your understanding of the law, in order to authorize involuntary hospitalization; minimal, moderate, substantial or overwhelming?

MR. PEEPLES:

Objection to the form.

MR. BROOKS:

What's the objection?

MR. PEEPLES:

Vagueness.

MR. BROOKS:

MR. PEEPLES:

Objection to the form. What are you talking about?

MR. BROOKS:

A person's severe violent behavior.

A. If it's in the hospital record, staff, from family, from the patient, the hospitals have something that is called a crim net that you can refer to.

Q. What is a crim net?

A. It's a list of all the arrests that the person has had. The last one -- I was here four years ago and it was in the records then. That's a way of getting information. You can get information from different sources. As I said, the family, client, record, clinics.

Q. Approximately how many patients do you examine pursuant to the 2 PC Law when you were at Hudson River?

A. Twenty to thirty, thirty to forty, something like that. Twenty to forty.

Q. Okay.

A. Two or three per year.

crack for the next hour to prevent the world from exploding, if it was that delusion, then I would say they are probably not dangerous.

Q. Would you agree that when assessing danger a clinician should differentiate between risk enhancing delusions and those delusions that are not risk enhancing?

A. Very much.

Q. Would you agree when a clinician assesses danger they should differentiate between risk enhancing delusions and those hallucinations that are not risk enhancing?

A. Yes. I definitely agree.

Q. Are stressors a risk factor?

A. I would say that they can be, yes.

Q. When would they be and when would they not be?

A. When a person had a particular vulnerability to react to a stress in a particular way versus a person who would react to a stress, but not in terms of hurting himself or others, but just in terms of discomfort, dysphoria. It doesn't necessarily make them

possibility -- (interrupted)

A. Command hallucinations.

Q. Hallucinations or delusions under some circumstances.

A. Okay.

Q. The role of stressors.

A. Yes, and maybe history of noncompliance with treatment might be a risk factor. I don't know if you mentioned that one.

Q. Okay.

A. Or even just a refusal to wanting to have treatment could be a risk factor. Motivation and history of treatment would be -- that's all I can think of right now.

Q. Now, Doctor, when assessing a person for commitment under the 2 PC Law, was it your practice to look at the person's history of substance abuse prior to determining whether or not the person is dangerous?

A. I would look at their history of substance abuse, yes, I would.

Q. How would you gather that information?

A. Often usually from the admission note.

Q. And if not from there?

they have a history of that, of hearing command hallucinations ten years ago doesn't mean they are a high risk factor now if they are in treatment.

Q. Would you agree that a person who doesn't suffer from dangerous hallucinations or delusions is less likely to cause harm than a person who does?

A. No, not necessarily.

Q. All things being equal?

A. All things being equal, I believe, yes, that there's a higher risk of a personal problem, probably all things being equal acting on a command hallucination. If a person doesn't have a command hallucination they wouldn't act on it, but doing an act that the voices tell them, then the person not hearing the voice does that act.

Q. Was it your practice to look at the role of stressors?

A. Yes.

Q. When determining whether or not a person met the criteria for commitment under the 2 PC Law?

talked to him his thinking was tangential and not direct. He appeared to be confused. Didn't have good judgment at the time from what I can extrapolate on that of what my insight and judgment findings were.

Q. Are you saying that this person was suicidal or he lacked the ability to meet his needs for food, medical, clothing or shelter or both?

A. I don't believe he was suicidal, but I believe that he was unable to care for himself in terms of consuming the alcohol and ending up making the accusations he did and getting himself arrested.

Q. Now, Doctor, let's look at -- I'm going to ask you to tell me if you agree or disagree with the following: Whether or not a person suffers from malnutrition or dehydration is an important consideration when determining whether or not a person is dangerous to himself because of an inability to meet basic needs?

A. Yes, I agree.

Q. Whether or not a person suffered from other

physical infirmities that went untreated is an important consideration when determining whether or not a person poses a danger to himself because of an inability to meet basic needs?

A. Yes.

Q. Would you agree or disagree whether or not a person has manifested a willingness to accept treatment is an important consideration when determining whether or not a person causes a danger to himself because of an inability to meet basic needs?

A. Yes.

Q. Would you agree that whether or not a person has manifested a willingness of treatment on an inpatient basis is an important consideration when determining whether or not a person poses a danger to himself because of an inability to meet basic needs?

A. Yes.

Q. Would you agree that whether or not a person has family members who are willing and able to provide support and, if necessary, assist in the treatment of the patient is an

important consideration when determining whether or not a patient poses a danger to himself because of an inability to meet basic needs?

A. Yes.

Q. Instead of me going through the entire question, I'm just going to give you other criteria and ask you to tell me if you agree or disagree that these are important considerations when determining whether or not a person poses a danger to himself. One, whether the person has manifested an ability to listen to those that have attempted to intervene and provide assistance?

A. Yes.

Q. Whether or not the person was in touch with reality?

A. To some degree. Not as much.

Q. Why not?

A. If they were willing to agree to get care and treatment, but their grip and other faces of reality were not too good, it wouldn't be that pertinent to meeting their

essential needs.

Q. Okay.

A. So if they had delusions of hallucination that didn't impact on their ability to get food and treatment and so forth, then that would not be a risk factor for them.

Q. Whether or not a person was properly questioned --

MR. BROOKS:

Withdrawn.

Q. Whether a person was able to obtain properly and store and preserve food?

A. Properly what? Obtain and store food?

Q. Yes.

A. Yeah, that's important.

Q. Whether a person was able to handle money in a fashion satisfactory to complete minimal self-maintenance transactions such as being able to make correct change?

A. Right. That's important.

Q. Whether or not a person was living in squalor?

A. That's important.

Q. Why is that?

A. How neat they are is not that essential in terms of them getting essential food and care.

Q. When you examined patients pursuant to your two physician examination certificates of Hudson River, were these all important considerations at the time you evaluated these people?

A. Yes.

Q. Now, Doctor, would you agree that some, if not most, of the 2 PC evaluations you conducted at Hudson River were done involving patients that were transferred from jail?

A. I'd say some of them were. Maybe out of those thirty that I had mentioned, maybe ten.

Q. Let's talk about those that were transferred from jail. Would you agree that when assessing whether or not a person suffered from malnutrition you would want to determine whether or not they were suffering from malnutrition prior to their admittance to jail?

A. Yes.

Q. Would you agree that a jail could meet a lot of basic necessities about what we just discussed?

A. Yes.

Q. Would you agree that with all these factors about which we have just spoke, you would want to assess the individual at the time prior to admittance to jail?

A. I'm not understanding the question.

MR. BROOKS:

Question is withdrawn.

Q. You said -- you acknowledged that whether or not a person suffered from the physical infirmities was an important consideration; correct?

A. Yes.

Q. Would you not want to know whether or not this person was suffering from other physical infirmities at the time of his admittance to jail?

A. Yes.

Q. To the best of your recollection, did Elmer Cade manifest any symptoms or engage in any

behaviors other than that noted here that led you to conclude that he posed a danger to himself or others?

A. I don't recall, you know. I don't recall. I always review the record and talk to the staff and so forth, but I don't recall what the record and all the things that I read in the record were. To the best of my knowledge, this is what I know now. I don't even recall seeing the gentleman or what he would look like four or five years ago unfortunately.

Q. Now, Doctor, why is the fact --

MR. BROOKS:

Strike that.

Q. Why did the fact that Elmer Cade made allegations that he found dead bodies help make him dangerous to himself?

A. Well, it shows that he was psychotic, delusional at the time and suffering from a mental illness. The fact that he was dangerous I think was the fact that he ended up getting himself arrested, doing enough with those delusions getting himself

arrested and incarcerated and also drinking heavily with no insight in judgment. I don't know what his motivation was to stop. And also his current mental status where his thinking wasn't clear.

Q. You said earlier that not all delusional people are dangerous?

A. Correct.

Q. What was it with this person's delusions that heightened the risk of causing harm to himself?

A. As we said before, when you act on your delusions to the extent of reporting it to the police and being that concerned and all of that, that is a dangerous thing. The inability for him to rationally understand his situation led me to believe that he was dangerous.

Q. To himself?

A. Yes. To himself, yes. He was dangerous to himself. And the fact that a person drinking heavily in and of itself is not dangerous, and the fact that a person feeling there are dead bodies around isn't

dangerous, but coupled with the fact that he was arrested for it and when I examined him he was still confused and his speech was not goal directed and there was a hint of a thought disorder with tangential thinking, that all coupled with the fact that his insight wasn't very good, that all coupled together made him dangerous is what I assumed from my write-up here. It has to be taken all together.

Q. Would you agree that confusion in and of itself doesn't make a person dangerous?

A. I would agree.

Q. Would you agree that suffering from a thought disorder does not make a person dangerous in and of itself?

A. Yes.

Q. Would you agree that having impaired judgment and insight does not make a person dangerous in and of itself?

A. Yes.

Q. Did you attempt to determine --

MR. BROOKS:

Strike that.

Q. Would you agree that in concluding that Mr. Cade posed a danger to himself because of an inability to meet his basic needs you had to conclude that his inability was so great that he could not meet his essential needs of food, clothing, shelter -- (interrupted)

A. Yes.

MR. PEEPLES:

Let him finish the question.

MR. BROOKS:

Q. Would you agree that a person who was confused might still be able to meet his essential needs of food, clothing, shelter?

A. It might be, yes.

Q. What was it about Mr. Cade's confusion that led you to believe that such confusion would impact on his ability to meet his basic needs of food, clothing and shelter?

A. I would say probably what -- I don't remember exactly my thinking, but probably the fact that he got arrested, that he made these accusations and got himself arrested, that if he was that confused that he probably was not able to get his clothing

history. It's vague in terms of what that would entail.

Q. What was it about his thought disorder that led you to conclude that it, meaning such thought disorder, would impact on Mr. Cade's ability to meet his essential needs of food, shelter and clothing?

A. That he couldn't answer my questions in a goal directed way, that he was still suffering from a thought disorder.

Q. What do you mean, "a goal directed way"?

A. That if I asked him something and he started talking about some other things and then got maybe back to what I was saying. Confused, I'm not sure what the confusion was. Now I don't remember, but he seemed like he was confused about his situation, why he was there in the hospital, what he had done or what he could do to get himself well or so forth in his confusion.

Q. Would you agree that some people who are tangential can still meet their basic needs of food, shelter and clothing?

A. Yes.

Q. Would you say that some people that are confused --

MR. BROOKS:

Strike that.

Q. Would you agree that some people who suffer from impaired insight and judgment can meet their essential needs of food, clothing and shelter?

A. Yes.

Q. What was it about Mr. Cade's impaired insight and judgment that impacted adversely on his ability to meet his essential needs of food, shelter and clothing?

A. I don't recall now.

Q. What was it about his thought disorder that led you to believe such thought disorder impacted adversely on his ability to meet his essential needs of food, clothing and shelter?

A. Other than the fact that he was so confused that he was calling the police and getting himself arrested, other than that I don't recall.

MR. BROOKS:

A. Yes.

Q. Would you agree that some people who are arrested and charged with a crime have not necessarily committed the act in question?

A. Yes.

Q. Now, what led you to believe that he, in fact, committed the act in question?

A. I don't recall.

Q. Did you make any attempt to determine whether or not he committed the act in question?

A. I'm sure I did, but I don't recall what it was.

Q. So you do not recall --

MR. BROOKS:

Withdrawn.

Q. Is it fair to say you do not recall asking Mr. Haynes whether or not he committed the act in question here?

A. I imagine that I asked him. I don't recall the interview at all from six years ago. I don't even remember seeing the gentleman, to be honest, not at all.

Q. Would you agree that depending on the facts

of his arrest, the fact that he was arrested may or may not have heightened the risk that he would cause harm to himself or others?

A. I think the fact that a person gets arrested that is mentally ill usually raises your concern about their potential harm for self or others when they are in the midst of a psychotic episode.

Q. Would the fact that he was arrested increase the risk that he would harm himself or others even if he was only arrested?

MR. PEEPLES:

Objection to the form.

A. Depends on how he came to the attention of the police and exactly what he did. Certainly that would mitigate him being dangerous if he was wrongly arrested, whether it would be in his favor of not being as dangerous, yes.

MR. BROOKS:

Q. Would you agree with the fact that a person who has pressured speech may or may not heighten the risk of him causing harm to himself or others?

Q. Would you agree with the fact that a person who has poor judgment may or may not increase the risk of harm that the person poses to himself or others?

A. Yes.

MR. BROOKS:

Off the record.

(OFF THE RECORD DISCUSSION)

Q. Now, Doctor, would you agree that what you wrote about the patient being arrested and having pressured speech, flight of ideas would be you setting forth what you found to be the patient's signs and symptoms of mental illness?

A. Yes.

Q. Can you recall anything about any of the signs and symptoms about which you noted that heightened the risk of harm that this person posed to himself or others?

MR. PEEPLES:

Read that back.

(QUESTION REPEATED BY REPORTER)

A. I don't recall, sorry.

MR. BROOKS:

Q. Let's go back to Barbara Dudas. Would you agree that the fact that she was extremely paranoid would not in and of itself heighten the risk of harm that she would cause to herself or others?

A. Yes.

Q. Would you agree that you would want to know whether or not Miss Dudas was --

MR. BROOKS:

Withdrawn.

Q. Would you agree in determining whether or not her paranoia would have heightened the risk of harm that she posed, you would want to know whether or not she intended to act on such paranoia?

A. Yes.

Q. Would you further want to know whether or not Miss Dudas had a history of acting upon paranoia?

A. Yes.

Q. Would you agree that if Miss Dudas had no intention to act on her paranoia and did not have a history of acting on paranoia she would be far less dangerous than she would be if she intended to act on the paranoia and had a history of paranoia?

MR. PEEPLES:

Objection to the form.

A. Yes.

MR. BROOKS:

Q. Would you agree with the fact that she was delusional in and of itself did not necessarily heighten the risk of harm that she posed to herself or others?

A. Yes.

Q. Would you agree that if Miss Dudas did not have an intent to act on her delusions she would be less dangerous than she would be if she had acted on her delusions?

MR. PEEPLES:

Objection to the form.

A. Yes.

MR. BROOKS:

Q. Would you agree if she had a further history

of acting on delusions she would be more dangerous than she would have been had she no history of acting on delusions?

MR. PEEPLES:

Objection to the form.

A. Yes.

MR. BROOKS:

Q. Would you agree that the fact she was psychotic in and of itself would not heighten the risk that she posed to herself or others?

A. I guess, yes. It's hard to say.

Q. Okay.

A. Each thing in and of itself, we established that psychosis, delusions, paranoia, in and of itself are not necessarily dangerous, it just depends on the context.

Q. Would you agree that the fact that she was hypomanic in and of itself did not heighten the risk of harm that she posed?

A. Yes.

Q. What word comes after hypomanic?

A. Severe flight of ideas.

Q. What are flight of ideas?

dangerous to herself or others if she wasn't threatening?

A. I think threatening makes you more dangerous.

Q. Even if you are threatening to sue?

A. Well, that kind of threatening. I meant threatening to hurt someone, not threatening a law action.

Q. Do you recall how she was threatening?

A. I don't recall that.

Q. Would you agree that the fact she was easily tearful would not in and of itself heighten the risk of harm?

A. I would agree.

Q. Would you agree that the fact that a person is confused, would not necessarily impact on -- (interrupted)

A. Yes.

MR. PEEPLES:

Wait for the question.

MR. BROOKS:

Q. Namely the risk of harm?

A. Yes.

Q. Take into consideration of how she was --

MR. BROOKS:

Withdrawn.

Q. Could you think of how Miss Dudas's extreme confusion would have heightened the risk of harm that she posed to herself or others?

A. I don't recall.

Q. Could you think of a situation, any situation, how suffering from extreme confusion would increase the risk of harm?

A. Yeah, if one was not able to cross the street correctly and negotiate getting their food correctly and/or were going up to the wrong types of people and misidentifying them and getting themselves harmed in a big city or something.

Q. Would you agree that when looking at the dangerousness of someone who suffers from extreme confusion, it's far more important to know whether or not the person was, in fact, having difficulty crossing the street -- (interrupted)

A. What specifics, yes, would be helpful.

Q. Then it would be to just know whether or not the person suffered from confusion?

would be a mitigating measure of the Provachol?

A. I guess, yes.

Q. Would it be important to know whether or not there were mitigating factors or mitigating measures when assessing a person's dangerousness?

A. Yes.

Q. If someone were reviewing a hospital chart -- give me an example of --

MR. BROOKS:

Strike that.

Q. Can you lay out all the mitigating measures when assessing danger to others?

A. All the what?

Q. In connection with assessment of danger to others?

A. Well, if someone has a history of alcohol and substance abuse, but yet they have someone that's a good support system there to help them and to notify and support them and if they slip, to kind of set them straight, that would be a mitigating force for that mitigating circumstance for that

risk factor of substance abuse. Or if someone had a history of noncompliance with medication and they stopped the medication, but now they said look, I'll take the injection every three weeks so you don't have to worry about that, that's not going to be an issue anymore, then I guess that would be a mitigating factor against noncompliance as a risk factor. If someone was not eating properly and not taking their medication properly, but yet they were going to a halfway house, that would be a mitigating factor because they would have supervision with that eating and medication, so even if they didn't know on the one hand to take it properly they wouldn't really be dangerous if they were going to a halfway house.

Q. Okay.

A. Those are some examples.

Q. Are there any mitigating measures that relate to history of violent behavior as a risk factor?

A. I suppose there are. I can't think of any

supervised more carefully.

Q. Anything else?

A. I can't think of any.

Q. How about mitigating measures, if any, stressors, anything else that you can think of for the role of stresses? In other words, mitigating risk that may result from stressors?

A. I guess medication.

Q. How about mitigating measururres that relate to threat or harm from inability to meet basic food needs?

A. I would say a supervised setting would be a good mitigating factor, family support and involvement.

Q. Any other mitigating measures that relate to -- I guess as a whole a person's inability to meet their needs for food, clothing or shelter?

A. Not that I can think of. Medication, family support and having the financial means to support oneself.

Q. How about support from other means such as community assistance program?

A. Sure, and clinics and outpatient therapy.

Q. Would you agree that you would want to look at the person's willingness to participate in such treatment?

A. Yes.

Q. Would you agree that's another way of asking whether that person would be complying with treatment?

A. Whether they would be willing to, yes.

Q. Participate in such activity?

A. Yes.

Q. Now, Doctor, earlier on you said you assessed twenty to thirty people for evaluation pursuant to the 2 PC Law?

A. That was a guesstimate, yes.

Q. In any of those situations or evaluations --

MR. BROOKS:

Strike that.

Q. In any of those evaluations, can you recall an instance when you reached the conclusion that a person required inpatient hospitalization, but was not dangerous?

A. I don't recall that.

Q. So would you agree you cannot recall a

situation where you say this person needs hospitalization, but I have to let this person go because -- (interrupted)

A. No, I've discharged people on 730-40s in my life before the seventy-two hours.

Q. Can you think of a situation where a person needed inpatient care?

A. Yes. And then let them go because they weren't dangerous?

Q. Yes.

A. I don't recall that. I might have. If they needed care and I felt that they wanted to leave and they wouldn't be dangerous to themselves or others, they would be able to have enough support and mitigating factors out there to help them, then I would discharge them.

Q. Can you recall a situation where you did that?

A. It's been so many years, sir, that I can't recall that. I've been doing these things too at CDPC, between eighty and ninety. I saw many, many patients there too. Many of them went -- I don't see quite as many in

this institution as in that one for some reason, but I don't know why. Different cases. I don't recall. The mitigating factors where they required further treatment in the hospital, but were not dangerous, I don't remember that.

Q. Do you remember evaluating people who you recall should be discharged prior to the seventy-two hours?

A. I'm not sure if it was this hospital or another. I do recall that happening, yes.

Q. Just for the record, when we are talking about discharging people within seventy-two hours, are you referring to the Office of Mental Health rule that says you need to evaluate people remanded pursuant to CPL 730-40 and discharge within seventy-two hours?

A. Yes.

MR. BROOKS:

Let's mark this.

(CERTIFICATE OF EXAMINING PHYSICIAN, KEVIN WASHINGTON, WAS RECEIVED AND

whether Mr. Haugh suffered from malnutrition prior to his being arrested?

A. That would be one factor and that would help assess it.

Q. Would it be useful to know whether he was suffering from any harm that may have resulted from his delusions?

A. Yes. It would be useful to know if he had ever attempted suicide or if he had ever harmed himself or others.

Q. Is there any indication from your note that he did engage in these acts at any time?

A. No. There's no reference to the past use harm towards others.

Q. Would you agree that the fact that he was extremely paranoid and suspicious in and of itself would make him dangerous?

A. In and of itself, but it's not a good sign when he feels the food is being poisoned. In and of itself, paranoia, suspiciousness out of context are not necessarily dangerous behaviors.

Q. Would you want to know how this person acted as a result of this paranoia and

suspiciousness?

A. Yes, I would.

Q. Would you agree the fact that he had a withdrawn affect would not in and of itself heighten the risk of harm?

A. I would agree.

Q. Would you agree with the fact that he was deprived would reduce the risk that he posed?

A. Yes.

Q. Would agree that the fact he was inappropriate would not heighten the risk of harm?

A. Yes.

Q. Would you agree his being impaired would not heighten the risk of harm?

A. Yes.

Q. Would you agree to want to know whether or not any of these signs and symptoms increase the risk of harm that he posed that you would have to know about other additional behavior in which he engaged in to assess whether or not any of these symptoms increased the risk of harm?

A. That would be helpful, but things taken in and of themselves isolated, it's like taking ten sticks and holding them together, it's a lot stronger, so when I have several different signs of mental illness, depression, withdrawn, plotting, each one in and of itself does not lead to dangerousness. All of them together certainly raises the dangerousness because of the more global dysfunctioning of the person in terms of their psychosis, so even though if a person is just paranoid that in and of itself is not necessarily dangerous, but if a person is paranoid, depressed, flight of idea, recently been arrested and confused, etcetera, sometimes the things taken together one would abstract to a more higher level of dangerousness because of the number of different facets of dysfunction in the behavior and thinking.

Q. Let's take Mr. Haugh as an example. Can we agree that you believed he posed a danger to himself only because of an inability to meet his basic needs of food, clothing and

against him, I'd have to review that to see if he threatened the staff, if he thought their actions were warranted to take revenge. I don't know the specifics of exactly how he acted on those behaviors at the time without reading through the record and talking to the staff.

Q. In terms of assessing whether or not he posed a danger to others, would it be more important to know that he was paranoid and suspicious or whether or not he acted on his paranoia and suspiciousness?

A. It would be important -- both would be important.

Q. Which would be more probative of an increased risk of harm?

A. Probably a history of acting out on his paranoia and suspiciousness.

Q. Would a manifestation of paranoia and suspiciousness be more probative of an increased risk of harm than an intention to act on such paranoia and suspiciousness or would the intention to act on any paranoia and suspiciousness be probative of increase

risk of harm than paranoia or suspisciousness alone?

A. Paranoia and suspisciousness alone would not lead to intent to harm others. That coupled with a history of hurting others would be more provocative.

Q. As would an intent?

A. Or an intent.

Q. You just said, "provocative." Did you mean provocative or probative?

A. What's the difference?

Q. Provocative, provoking him all the time, doesn't make him probative of danger. In other words, provocative means you are provoking someone to engage in an act. Probative means there's evidence of something.

A. What's the question?

Q. When you used the word provocative -- I've been using the word probative.

A. I thought you meant provocative.

Q. I mean probative.

A. Okay.

Q. In other words -- you've heard all my

before, increase the risk of dangerousness than one isolated symptom because of the more global dysfunction in terms of more symptomatology that a person has.

Q. In talking about this global dysfunction --

MR. BROOKS:

Withdrawn.

Q. Earlier on in the deposition you said that a person who suffers from mental illness is not necessarily dangerous; correct?

A. Yes.

Q. Now, would you agree that a person who suffers from mental illness generally manifests more than one sign or symptom of mental illness?

A. Generally, yes. More than one sign or symptom.

Q. So you would agree then that a person who suffers from mental illness and manifests several signs and symptoms still may not pose a danger to herself notwithstanding the existence of several signs and symptoms?

MR. PEEPLES:

Objection.

A. Well, that's true sometimes, yes.

MR. BROOKS:

Q. Sometimes?

A. Yes.

Q. Would you agree further that in order to determine whether or not a person who suffers from mental illness poses a danger to herself or others as a result of the manifestation of several signs and symptoms you have to look at the existence of other factors or other behaviors that go beyond the particular signs and symptoms that the person manifested?

A. The ramifications of the symptoms, if you will.

Q. Right?

A. Right.

Q. Would an example of the ramification of the symptoms being with Barbara Dudas that when looking at her extreme confusion, whether or not the confusion resulted in her getting adequate food intake?

A. Adequate food intake, hurting others or herself, right.

Q. Same or similar.

A. May differ, yes.

Q. Please tell me if you agree or disagree with the following statement: Patients who manifest the same symptoms of mental illness may differ radically in their capacities to care for themselves to meet their basic needs?

MR. PEEPLES:

Objection to the form.

A. If those symptoms of mental illness are command hallucination to be violent, then they wouldn't differ radically necessarily. They probably would not differ radically. Certain symptoms, in other words, are more indicative of danger than others. For instance, a symptom of suicidal thoughts or obsession. If a person has that and a more suicidal intent, symptoms of that are certainly more significant than just depression without any suicidal thoughts.

Q. Would you agree that patients who manifest the same or similar symptoms of mental illness may differ radically in their

capacities to care for themselves or others depending on the particular signs and symptoms that are at issue?

MR. PEEPLES:

Objection to the form.

A. I suppose sometimes they may.

MR. BROOKS:

Q. Would you say that's a yes?

A. Yes.

Q. Please tell me if you agree or disagree with the following: Because patients with the same or similar diagnoses may differ radically in their capacities to care for themselves and meet their basic needs, in order to accurately assess whether a patient poses a danger to himself because of an inability to meet his basic needs, a clinician should prior to making a decision about dangerousness attempt to gather as much information as possible relating to the risk assessment criteria about which we spoke that relate to a patient's inability to meet basic needs?

MR. PEEPLES:

Objection.

A. Yes, that would be a good idea.

MR. BROOKS:

Q. And tell me if you agree or disagree. Because patients with the same or similar signs and symptoms of mental illness may differ radically in their capacities to care for themselves and meet their basic needs, in order to accurately assess whether a patient poses a danger to himself because of an inability to meet basic needs, a clinician should prior to making a decision about dangerousness attempt to gather as much information as possible relating to the above criteria connected with a patient's ability to meet basic needs?

MR. PEEPLES:

Objection to the form.

A. Yes.

MR. BROOKS:

Q. Please tell me if you agree or disagree with this statement: A key source of information about a patient's self-preservation and survival skills would usually be third

parties from the community who have observed and can describe the patient's self-preservation and survival skills.

A. Whether I agree with that?

Q. Yes.

A. Yeah, it's usually another party, I agree.

Q. In any of the patients that we spoke about today, can you recall speaking to a third party from the community who had observed the patient and could describe the patient's self-preservation and survival skills?

A. Well, I'm sure I talked to the staff, so I would say that on each of those people I probably had some information in terms of how they were doing before they came in the hospital and how they were doing in terms of while they were in the hospital from the staff, but in the admission note, which I'm not privy to right now, there is information in terms of what they were doing prior to the hospitalization.

Q. Okay.

A. I can answer that question further if you can read it back?

opinion.

Q. Now, Doctor, when assessing a person's dangerousness you said a person's criminal history is important?

A. It's of somewhat importance, yes.

Q. Would you agree that the Office of Mental Health has access to a person's criminal history?

A. Yes.

Q. Would it be your practice to attempt to gather a person's criminal history prior to making a determination about whether a person poses a danger to self or others when assessing the person pursuant to 9.27?

A. It would be helpful to have that.

Q. Was it your practice to gather that information?

A. I don't believe to be honest that when I did the 2 PC's that crim net was yet in the record. Although I would have liked that information on these particular case that you brought up today, I don't recall reviewing the crim nets, but there might have been reference to some of their

A. After reading the admission note and talking to the staff, like I said I did on each client, and then talking to the client, I wouldn't get that information if it wasn't there. If the client didn't tell me about it themselves either. I wouldn't necessarily call the therapist in the community or the family to get further information, so that if it wasn't in the admission note and it wasn't noted by the staff, dangerous previous behavior, and it wasn't told to me by the client, I probably wouldn't have it at the time of these examinations.

Q. What would be the best source of information regarding a person's impulse control, good or bad?

A. Best source of information would be probably the people that were living with this person recently.

Q. And was it your practice to attempt to speak to others who were living with this person?

A. Not to speak to them directly, but to gather information in terms of how they were

than not or less times than not?

A. Less times than not.

Q. Would you say you called people in the community far less times than not?

MR. PEEPLES:

Objection to the form.

A. Yes. I don't recall doing a 2 PC where the information wasn't there.

MR. BROOKS:

Q. How about substance abuse, what would be the best source of that information?

A. The admission note has a part of it that is supposed to address that and the patients themselves and staff again, anything that staff knew. And the outpatient department, if they had been in outpatient therapy, they would be contacted.

Q. How about person's family history?

A. Person's family history again is part of the admission note, most definitely.

Q. How about the role of stressors?

A. Role of stressors?

Q. Yes.

A. I would say that's inferred by the admission

taking care of the patient, a friend, someone that knows the person. And the patient themselves.

Q. And motivational treatment?

A. I assess that through mainly the patient himself.

Q. How about whether or not a person suffers from malnutrition prior to incarceration?

A. There's a physical exam that's done certainly on admission that is done within twenty-four hours and that would show dehydration or malnutrition.

Q. Would you agree that the person coming from jail you would have to go back and see how the person was in jail?

A. Yes. I would agree, yes.

Q. What would be the best source of that information?

A. Who the person was living with, where the person was prior to being there.

Q. How about jail records?

A. And my records.

Q. I said jail records.

A. Oh, jail records. I don't know that much

about the jail records, what they do.

Q. So it's fair to say you haven't seen many jail records?

MR. PEEPLES:

Objection to the form.

A. No, I haven't.

MR. BROOKS:

Q. How about whether or not a person has support of the community, what is the best source of information there?

A. The community.

Q. People in the community?

A. Well, where they were staying prior to the family.

Q. Not family members. With whom the person was living?

A. Well no, no. Just family members in general. Family members in general and outpatient therapists.

Q. What's the best source of information about whether or not a person had the ability to listen to others who attempted to provide assistance?

A. I'd say their family and therapist.

Q. When you say "therapist," do you know therapists in the community?

A. Yes.

Q. When you conducted 9.27 evaluations, did you ever attempt to contact a therapist in the community?

A. Not on these cases, no.

Q. On any cases involving involuntarily hospitalization?

A. Well, yes. Many 9.37 cases, all the time, every day.

Q. In other words, what you are doing now?

A. Yes. Before I go out on a 9.37, I'm calling the clinic, talking to the family, talking to the patient. It's a tremendous amount of information I guess.

Q. Is it useful information?

A. Very useful information, yes.

Q. You get this useful information from the therapist?

A. I get a referral to go out on the case and the person who refers the case, of course, who is concerned in the community whether it's a friend or a therapist, often it's a

Q. I want you to assume that paranoid and suspiciousness did not come on all of a sudden and he was not found to suffer from malnutrition and dehydration upon incarceration. Would that change your opinion whether or not he was a danger to himself?

A. Yes. It would reduce the danger to himself if the symptoms were long-standing and he had been eating all this time and not malnourished, it would reduce the risk of that particular symptom and that danger to himself.

Q. Would that reduce it to the point where you would not have found him dangerous?

A. That's hard to say without the admission note. If he was withdrawn and depressed and had two previous suicides -- (interrupted)

Q. I'm not talking about that.

A. Are you talking about the basis -- (interrupted)

Q. Meeting his needs.

A. Yes, it would have changed them.

Q. Let's talk about danger to self, suicide.

A. Okay.

Q. If he was felt to have no history of suicide attempts, would that have changed your opinion?

A. Yes.

Q. Okay.

A. It would have been changed -- I don't know if it would have changed my opinion, but it would have affected my opinion.

Q. How would it have affected your opinion?

A. If he had no history of suicide attempts or self-injurious behavior, the withdrawing and depressive feelings that he had with being less dangerous may be just as painful for him, but less dangerous in terms of him needing hospitalization in an inpatient setting.

Q. Would it have changed your opinion enough so that it would have resulted in you finding him not dangerous?

MR. PEEPLES:

Objection to the form.

A. It's hard to answer that. Perhaps.

MR. BROOKS:

over fences to get away. It says he does have some cannibus abuse and that makes him paranoid. Refusing to eat anything prepared, I don't know if that is going to increase and he will refuse to eat anything in general.

MR. BROOKS:

Off the record.

(OFF THE RECORD DISCUSSION)

Q. While you were at Hudson River, had you ever seen that the facilities -- the facilities for any reason use any risk assessment forms, have you ever seen that?

A. Yes.

Q. What did the risk assessment form entail?

A. On the 3/30/02 applications, I believe, sir, to the court for recommitments, I believe there's been a risk assessment section on that application that I've had to complete. That's the only one that I'm aware of. I haven't done it for awhile, but that's the only one.